Dept of Services for the Blind

Youth Employment Solutions

Wa. State School for the Blind

Youth Employment Solutions

2011 APPLICATION

I AM APPLYING FOR YES 2011:

Level 1 ☐ (Age 14 +)

Level 2 ☐ (Age 16+)

SECTION 1
MY INFORMATION:

Student's Name:

First: _____

Last: _____

SS#: (last 4 digits only) 000-00- _____

Home Address:

(Street)_____

(City)_____ State: _____ (Zip) _____

Student Email Address: _____

Birth Date: _____/ _____ / _____

Sex: Male ☐ Female ☐

Current School Grade: _____

I Prefer Materials in: Braille ___

Large Print ___ Regular Print____

SECTION 2
PARENTS/GUARDIANS
CONTACT INFORMATION

Father/Guardian

Name : _____ _____

Address: _____

(City)_____ State: _____ (Zip) _____

Best Contact Phone #: (_____) - _____ - _____

Email Address: _____

Mother/Guardian

Name : _____ _____

Address: _____

(City)_____ State: _____ (Zip) _____

Best Contact Phone #: (_____) - _____ - _____

Email Address: _____

Alternate Emergency Contact Phone Number:

Name: _____ Relationship to Student: _____

Contact Phone #: (_____) - _____ - _____

SECTION 3
VISUAL IMPAIRMENT/ DISABILITIES

Please define and describe your visual impairment

Eye Condition: _____ (Cause)

Please describe your visual acuity and functional limitations:

Please check the box that applies to you:

- ❑ Legally Blind.
  Acuity in Snellen equivalents is less than 20/200 even with ordinary glasses or contact lenses with the better eye or field of vision is less than 20° with the better eye.
- ❑ Low Vision.
  Acuity in Snellen equivalents is between 20/200 and 20/60 at distance or, at near (14"), is unable to read 10-point newsprint (this size print) even with ordinary glasses or contact lenses with the better eye.
- ❑ I do not meet these definitions of Legal Blindness or Low Vision.

Visual Acuity

Please fill in acuities if know.

Distance Without Correction:

O.D. 20/_____

O.S. 20/_____

O.U. 20/_____

Distance With Best Correction:

O.D.

O.S.

O.U.

Near Without Correction:

O.D.

O.S.

O.U.

Near With Best Correction:

O.D. _____

O.S. _____

O.U. _____

If acuities are not applicable please check the appropriate box below:

- ❑ Light Perception Only
- ❑ Waving Fingers
  @ _____ Feet (Distance)
- ❑ Totally Blind

Briefly describe how your visual condition affects your daily activities:

Please describe any other challenges associated with your eye condition (i.e. light sensitivity)

SECTION 4
MEDICAL/SPECIAL NEEDS INFORMATION

To insure the safety and well being of all students please provide full disclosure to the following questions. Lack of disclosure or incomplete information regarding medical, behavioral or emotional issues that could potentially interfere with a student's participation, or that could affect the safety and well being of YES participants and staff, could be grounds for termination from YES.

PLEASE DESCRIBE ALL MEDICAL CONDITIONS

Medical Condition #1: _____
Describe:

_____

_____

_____

Medical Condition #2: _____
Describe:

_____

_____

_____

Medical Condition #3: _____
Describe:

_____

_____

_____

Please describe any behavioral, social or emotional conditions:

_____

_____

_____

_____

_____

Please list any allergies you have to:

FOOD:

_____ _____ _____

_____ _____ _____

MEDICATION:

_____ _____ _____

_____ _____ _____

OTHER:

_____ _____ _____

_____ _____ _____

Please describe any dietary restrictions you have:

_____

_____

_____

SECTION 5
MEDICATIONS

Please list all medications and dosages:

MEDICATION NAME:	DOSEAGE	TIMES PER DAY	SELF ADMINISTER (Y OR N)
1)			
2)			
3)			
4)			
5)			
6)			

Please describe the level of assistance needed to the No answers in table above.

Medication — _____

Level of assistance needed:

_____

_____

Medication — _____

Level of assistance needed:

_____

_____

Medication — _____

Level of assistance needed:

_____

_____

Please describe any special accommodations you may need in order to participate, (i.e. wheelchair, access devices, interpreter, etc.)

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Please use this space to list and or describe any other medical, behavioral, social or condition not listed previously:

_____

_____

_____

_____

_____

SECTION 6
TEACHER/COUNSELOR

In order to determine both the level of proficiency and to plan a program that would be most beneficial for each student we need to have an evaluation done by the TVI or counselor that has worked with you.

Please provide the contact information below, and fill out and sign the enclosed Client Consent form so that we can discuss with your TVI/Counselor your readiness for the YES program.

TVI:

Name: _____

Title: _____

Phone #: _____Email Address: _____

Name of School: _____

Counselor:

Name: _____

Title: _____

Phone #: _____Email Address: _____

SECTION 7
EXTRA CURRICULAR ACTIVITIES

Describe extracurricular activities you are involved in (school, Church etc.):

_____

_____

Descibe any Special Interests :

_____

_____

List any Hobbies:

_____

_____

Favorite recreation:

_____

_____

_____

SECTION 8
WORK EVALUATION

Have you ever had any work experience? (Volunteer, part-time, full-time, etc.)
List each position and give brief description:

_____

_____

_____

Please describe any specific accommodations made during the experience?

_____

_____

_____

SECTION 9
JOB PREFERENCE

Summer jobs for high school students are generally found in one of the following areas. What would be your choices?

1 = Most Preferred —> 5 = Least Preferred

Please rank the following list:

Job	Rank
Clerical/Office Work	_____
Food Service	_____
Retail (Work in a store/market, etc.)	_____
Outdoor Work	_____
Child Care/Nursery	_____

Other: (Please Indicate)

_____

What skills and interests do you have that would help you perform the job you have selected as your number one choice from the list above:

_____

_____

_____